STATEMENT	OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER	R/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X;) DATE SUI COMPLET	RVEY ED
AND PLAN C	F CORRECTION		IDENTIFICATION NUN	MBER.	A. BUILDING B. WING		C 44/20	/2007
			09G171]		11/29	12001
NAME OF P	ROVIDER OR SUPF	IER:	·			TATE, ZIP CODE		
CARECO	11			1701 24TH WASHING	STREET, N FON, DC 20	002		
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1 000	INITIAL COM	ΛEΞΝ	TS		1 000			
	November 26 The survey w process. A ra selected from various degre The findings observations and staff, and incident repo revealed that	200 is initiated a point of the at the the the file.	was conducted from 7 through November itiated using the full sim sample of two residepulation of four femals of disabilities. It is survey were based of the survey of records, income of the survey of participation in Accord of Participation in Accord in the survey of the s	29, 2007. urvey lents were les with on ith clients cluding urvey compliance			2001 JAN -4 P 12: 27	RECEIVED RECEIVED REALTH REGULATION
1.045		AI C	SERVICE / DINING A	REAS	1 043		· -·	·
1040			all be as follows;	I (L) (O	, 5 , 5	The client's diet will be reviewed	 i by 1 1e	1/3/08
			east quarterly by a die	titian.		registered dictitian.	; ;	7 - 100
	Based on re- ensure that of modified die:	ord r ne o s had	ot met as evidenced b review, the facility faile f the three residents v d been reviewed at le onsulting dietitian.	ed to with				
	The findings	nclu	de:			,		
	November 2 the resident' assessed/re three month	', .20 nno- riewe . Th side	nt #1's medical recon 07, failed to show evi dified diet had been ed by the dietitian at le ne most recent quarte ent #1 had been docur	dence that east every only nutrition				
Health Reg	ulation Administra	iori					 ,	(VE) DATE

LABORATORY DIRECTOR'S O ! PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT AND PLAN O	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G171			R/CLIA MBER:	A BUILDING	LE CONSTRUCTION	(XE) DATE SUI COMPLET	ED
			09G171				11/29	12001
	ROVIDER OR SUPF	JER.		1701 24TH	STREET, N	TATE, ZIP CODE		
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1,058	Continued Fro		age 1		1 058			ļ
			RVICE / DINING AR	EAS	1058			
	A review and nutritionist shensure that e	ch od III odi nodi ding	sultation by a dietitian e conducted at least o resident who has bee fied diet receives ade g to his or her Individu	or quarterly to n equate				
	Based on rec ensure that o modified diet	ord the or he o	ot met as evidenced be review, the facility faile f the three residents we d been reviewed at le consulting dietitian.	ed to with				
	The findings	ncilu	de:					
	November 2 the resident's assessed/rethree months	, 20 mlocietwe Th side	nt #1's medical recor 07, failed to show evi dified diet had been ed by the dietitian at k ne most recent quarte nt #1 had been docu	dence that east every erly nutrition				
1 082	Each bathro- equipped wit	m th i toil ap t	OMS AND BATHROO nat is used by resider let tissue, a paper tov for hand washing, a n	nts shall be vel and cup	1082	The Residential Director (RD) viscap and paper towels are alway bathroom. The RD will ensure available in the bathroom.	s avails ble in the	1/3/08
	Based on ot properly equ	p ea	ot met as evidenced lation, the GHMRP fai ach bathroom with the to meet each reside	iled to				
	The finding		des:	···			· · · · · · · · · · · · · · · · · · ·	
Health Reg	ulation Administra RM	iori			8890	UKU111	If continua	ation sheet 2 of 14

STATEMENT AND PLAN OF	OF DEFICIENCIES CORRECTION	C	X1) PROVIDER/SUPPLIE IDENTIFICATION NUM		(X2) MULTIF A, BUILDING B. WING	LE CONSTRUCTION	•	ETED C
			09G171		1 =		11/2	9/2007
NAME OF PR	OVIDER OR SUPP	1EI't	-			TATE. ZIP GODE		
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1 082	Continued Frc	n pag	g e 2		082			
	AM, no soap 1 mirror were a	or han ail ab k	007, at approximate and washing, paper to be in the first bathro s and staff usage us	owels or om in the			:	
1 095	3504.6 HOUS	EKEE	PING		1 095	· · · · · · · · · · · · · · · · · · ·		
	Each poison a locked cabii of each residu	el an	austic agent shall be id shall be out of din	estored in ect reach		The RD will ensure that caustic ages stored in the food preparation area.	ats an not	1/3/08
	Observation a	nd int I to er	met as evidenced beterview revealed that naure that caustic a	it the gents were			·	
	The finding in	clude	s;					
	November 29 caustic agen	, 2!007 s \ver (mental inspection of 7 at approximately a re observed stored in a cabinet undernea	11:00 AM, n a food				
 1096	3504.7 HOU	EKE	EPING		1096			
	No poisonou	; or ha	azardous agent sha on, storage or servii	ill be stored ng area.		See response above.		1/3/08
	Observation GHMRP faile	and in d ko e	t met as evidenced nterview revealed th ensure that caustic a good preparation and	at the agents were				
	The finding i	g i nc.udes:				•		-
Health Reg	ulation Administra	Ori			<u> </u>			

CARECO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION NAME OF PROVIDER OR SUPP		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A, BUILDING B. WING		(X3	(X2) DATE SURVEY COMPLETED C 11/29/2007		
NAME OF P	ROVIDER OR SUPP	IEI?		STREET ADD	RESS, CITY.	STATE, ZIP CODE			·
CARECO	11				4TH STREET, NE NGTON, DC 20002				
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1 096	Continued Frc	n pa	age 3	·	1 096			}	
	November 29, caustic agents	200 Wer	mental inspection on 7 at approximately 1 re observed stored in a cabinet undernea	1:00 AM, a food					
1 135	3505.5 FIRE	AFE	≣ΤΥ		ı 135	! ! ·			
	order to test t	e ef	all conduct simulated ffectiveness of the pl ar for each shift.			The move to the facility took plants of the QMRP and RD will ensure take place as scheduled quarterly that the drills are properly documents.	that fire d y on all sh	ills ifts, and	1 1
	Based on inte GHMRP faile	viev to e	it met as evidenced by wand record review ensure that each shif rill four times a year.	the t				1 	i /3/68
	The finding in	slud	es:					1	
•	Professional pattern on No	vem QIVII	Qualified Mental Ref RP) and review of the ober 29, 2007 at appr d the scheduled shift	e staffing oximately				} } !	
	Weekdays 1st Shift 7 Al 2nd Shift 3 P 3rd Shift 11 F	/ 1 '!o	11 PM						
	Weekends						. •		
	1st 7 AM to 7 2nd 7 PM to							; 	
[]	the staff was	requ :h st	with the QMRP reve lired to conduct a dri nift. Review of the fir	II once per					

	T OF DEFICIENCIES OF CORRECTION		(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		A. BUILDING	PLE CONSTRUCTION	(X 1) DATE SI COMPLE	TED
			09G171		B. WING			9/2007
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l 135	Continued Fro	m pa	ge 4		I 135		ı	
	evacuation dr (April 2007).	ls sir here	the facility failed to hace their move into the was no evidence the duarterly on all sh	e facility at fire				
1 167	3507.4(e) PO	TCIE	S AND PROCEDUR	ES	l 167		I	
			ncorporate policies areast the following:	nd				
	qualifications,	staff	th covers job descrip resident ratios, traini health inventory;				í	
	Based on rev Mentally Reta ensure that the included a podescriptions a	ew of ded eir Po ey to not qu	met as evidenced by records the Group Fersons (GHMRP) folicies and Procedure address personnel, ualifications, staff/restaff development, a	lome for ailed to es' Manual job ident				
	The finding in	dude	s:					
	November 28 a policy that a descriptions a	200° ddres nd qu	ies and procedures of failed to provide ex seed personnel, jobualifications, staff/res staff development, a	ridence of ident				
	descriptions	ioir sh /ith ei ind a	EL POLICIES nall discuss the conte ach employee at the t least annually there	beginning	I 203	The job descriptions will be reviewed staff annually. Those who were not a timely will be completed.	d w th the	1/3/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION NAME OF PROVIDER OR SUPF		IDENTIFICATION NUMBER: 09G171		A BUILDING		1		
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1 203	Based on rec provide evide the contents c employee at t and annually f	: riot and n ce ti i job le be heire: :lude	met as evidenced by eview, the GHMRP far the supervisor dis descriptions with each eginning of their emplanter.	eiled to scussed ch loyment	1 203			
I 206	2007 failed to care staff (#8 descriptions h	personnel files on November 29, provide evidence that five direct #9, #10, #13 and #14) job ac been reviewed. ONNEL POLICIES			l 206	<u></u>	: _ _ -	
	annually there certification the performed an	after at a I tha	rior to employment ar r, shall provide a phys health inventory has it the employee 's he her to perform the re	sician ' s been alth status		The Human Resources Director will estaff and consultants have current heal certificates signed by a physician on fi	th	1/3/68
	Based on inte	rviev o aci rtain	t met as evidenced bus and record review hieve compliance with hing to health (22 DC) on 3509.6).	, the h State			;	
	of personnel which time th care staff (St one medicati	uliato edor are v aff #3 an nu alogía	es: ory agency conducted ds on November 29, vas no evidence that 3, #9, #10, #11, #13, urse (Nurse #2), Podi st and Occupational	2007, at six direct and #14). atrist,				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION NAME OF PROVIDER OR SUPP		IDENTIFICATION NUMBER: 09G171		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X) DATE SU COMPLE	TED		
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1 206	Continued Fro	m pa	ige 6		I 206				
	had current h	aļth ·	certificates.	1			1		
l 2 24	3510.5(a) ST.	.FF1	FRAINING		I 224 -	·	ļ		
	Each training, limited to, the		am shall include, but ving:	not be		The QMRP will provide training to sta Overview of Mental Retardation.	affon an)) 0	
	not limited to, retardation, a frequently usr	dejfin socia d ne	intal retardation incluition, causes of mentated health implication dications, the history mental retardation, and	ns, and of care			•	1/3/68	
	Based on obs review, the G	erivat NIRI	met as evidenced by ion, staff interview ar P failed to ensure eff e to each staff.	nd record			1		
	The finding ir	slude	ı:				;		
	2007, reveals	d i ha	ing records on Nover t the GHMRP failed t of mental retardatio	o provide					
I 225	3510.5(b) ST	₹F	TRAINING		I 225		-1		
	Each training limited to, the		ram shall include, but wing:	t not be		The QMRP will provide training to st Human Development.	taff on	1/3/08	
	(b) Human di (birth to deatl		oment through the life	e cycle		·	!		
	Based on rec	and re	met as evidenced by eview, the GHMRP fa aining was provide to	illed to					
	The finding in	cliµde	es:						

NAME OF P	OF DEFICIENCIES OF CORRECTION ROVIDER OR SUPF	(DE)		STREET ADD	A. BUILDING B. WING DRESS, CITY, S	STATE, ZIP CODE	(X:) DATE SI COMPLE : 11/2	TED
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1 225	Continued Fro	n page 7			1 225			
		triat the GH	rds on Noveml MRP failed to p ment.					
l 227		ուրgram sha	IG Il include, but r	not be	I 227	The RN Supervisor will provide training on infection control.	ng () staff	1/3/08
		ontrol for sta	ff and residents	≱ _				7/3/9
l 228	3510.5(e) ST. Each training limited to, the	TRAINING TO THE TRAINING THE		not be	1 228	The QMRP will provide training to s Resident's Rights.	tafi où	1/3/08
	Based on rec	s hot met as	evidenced by: ne GHMRP fail as provide to e	ed to			, ; !	_
		training reco	ords on Novem IMRP failed to ts.			·		
l 229	3510.5(f) ST, Each training limited to, the	; pr ogram sha	IG all include, but I	not be	I 229	The QMRP will provide training to st resident's needs in behavior supports technology and sexuality.	aff on each	,/3/08
Health Beau	lation Administrat				 .			<u> </u>

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IPF JER	-	STREET ADD	RESS, CITY, S	TATE, ZIP CODE		i	
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FI IENO	Y MUST BE PRECEDED BY	FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU	JL(: B	E	(X5) COMPLETE DATE
to al constant of the trained	related to the GHMRI rved including, but not agement, sexuality, nut ommunications, and as of met as evidenced by of training documents, provide evidence to vadicated by residents' res: ning records on Novements and records on Novements are records on Novements and reco	limited rition, ssistive the lidate need.	I 229				
or AFF ag prophe folion itic 1 pla es and be enviole for all by ve s pro to nab es affect y- it clud for ited to the brig roctive	gram shall include, but bwing: anning and implements of met as evidenced by ation, interview and recovided to ensure that expectively, efficiently, and destined the employee to pectively, efficiently, and destined the employee to pectively.	ation; cord each continuing erform his as capable ats #1 and Individual	1 230	The QMRP will ensure that staff are t clients' individual Support Plans and Habilitation.	raine Ax tiv	d on ve	1/3/08
A CL IVER YOU'LE SELVE HEAVEN SO THE METERS OF A SHIPE	MACHINE TO THE SECOND TO THE SECOND TO THE SECOND THE S	DENTIFICATION NUM 09G171 UPF LIER MAX Y STATEMENT OF DEFICIENCIES EFF IE NOY MUST BE PRECEDED BY OR "CR LSC IDENTIFYING INFORMAL From page 8 Y a exis related to the GHMRI ob a served including, but not r n an agement, sexuality, nut to all communications, and as es; e si lot met as evidenced by every of training documents, ille to provide evidence to va- gris indicated by residents" in the training records on Noven GH VIRP failed to provide train har agement, assistive technolity ST AFF TRAINING In planning and implements the sinot met as evidenced by the following: Into I planning and implements the sinot met as evidenced by the following: Into I planning and implements the sinot met as evidenced by the following: Into I planning and implements the sinot met as evidenced by the following: Into I planning and implements the sinot met as evidenced by the following: Into I planning and implements the sinot met as evidenced by the following: Into I planning and implements the sinot met as evidenced by the following: Into I planning and implements the sinot met as evidenced by the following: Into I planning and implements the sinot met as evidenced by the following: I planning and implements the sinot met as evidenced by the following: I planning and implements the sinot met as evidenced by the following: I planning and implements the sinot met as evidenced by the following: I planning and implements the sinot met as evidenced by the following: I planning and implements the sinot met as evidenced by the following: I planning and implements the sinot met as evidenced by the following: I planning and implements the sinot met as evidenced by the following: I planning and implements the sinot met as evidenced by the following: I planning and implements the sinot met as evidenced by the following: I planning and implements the sinot met as evidenced by the following: I planning and implements the sinot met as evidenced by the following: I planning and implements the sinot met as evidenced by	DENTIFICATION NUMBER: 09G171 UPF LIER 1701 24TH WASHING MAY TATEMENT OF DEFICIENCIES EFF IENCY MUST BE PRECEDED BY FULL OR "CR LSC IDENTIFYING INFORMATION) From page 8 y a cuts related to the GHMRP and the poly served including, but not limited in an agement, sexuality, nutrition, to all communications, and assistive eas; e silot met as evidenced by: every of training documents, the life it provide evidence to validate go sindicated by residents' need. If It is training records on November 9, 3H VIRP failed to provide training on the agement, assistive technologies lifty ST AFF TRAINING In planning and implementation; the shot met as evidenced by: be evaluation, interview and record if all the fallowing: In the training records on the provide with initial and continuing and its provided with initial and continuing at a nabled the employee to perform his estimated to the employee to perform his entire the employee to perform his entire the employee to perform his employee to perform his employee	Definition Number: Defini	DENTIFICATION NUMBER: 09G171 STREET ADDRESS, CITY, STATE, ZIP CODE 1701 24TH STREET, NE WASHINGTON, DC 20002 PROVIDERS PLAN OF CORRECT (RACH CORRECTIVE ACTION SHOLL OF CALSC IDENTIFYING INFORMATION) Fir im page 8 1 229 Je eas related to the GHMRP and the bisserved including, but not limited in all argement, sexuality, nutrition, to all communications, and assistive every of training documents, the life bis provide evidence to validate gisser including to the training records on November 9, 3H M/RP failed to provide training on lar agement, assistive technologies lity ST NFF TRAINING 1 230 The QMRP will ensure that staff are to clients individual and continuing at mabled the employee to perform his assistive individual and continuing at mabled the employee to perform his assistive Hast staff was capable the first individual and continuing at mabled the employee to perform his assistive Hast staff was capable the first individual and continuing at mabled the employee of perform his assistive Hast staff was capable the training of Clients #1 and in cludes: 1 field to ensure that staff was capable the big understanding of Clients #1 and in clude Habilitation and their individual ar 3 (ISP). (See W196 and W249)	Dentification Number Ogg171 JUPF JER STREET ADDRESS, CITY, STATE, ZIP CODE 1701 24TH STREET, NE WASHINGTON, DC 20002 PROVIDERS PLAN OF CORRECTION OF "CRUSC IDENTIFYING INFORMATION") PREFIX TAG FIR III page 8 1 229 Je exist related to the GHMRP and the oblighered including, but not limited an anagement, sexuality, nutrition, to all communications, and assistive exists. Existing a series of training documents, the limit of all communications and assistive exists in a series of training on the provide evidence to validate go is indicated by residents' need. Jir 'Aldes: The QMRP will ensure that staff arc trained clients' individual Support Plans and Artist Habilitation. The QMRP will ensure that staff arc trained clients' individual Support Plans and Artist Habilitation. The QMRP will ensure that staff arc trained clients' individual Support Plans and Artist and the employee to perform his as affectively, efficiently, and light of the continuing at in abled the employee to perform his as affectively, efficiently, and light of the continuing at in abled the employee to perform his as affectively, efficiently, and light of the continuing at in abled the employee to perform his as affectively, efficiently, and light of the continuing at in abled the employee to perform his as affectively, efficiently, and light of the continuing at the provided with initial and continuing at in abled the employee to perform his as affectively, efficiently, and light of the continuing at the provided with initial and continuing at in abled the employee to perform his as affectively, efficiently, and light the continuing at the provided with initial and continuing at the pr	Description Number: Description Number: Description Number:

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1 232	Continued Fro	וְת	page 9	-	1 232		1	
l 232	3510.5(i) STA	F	TRAINING		l 232			
	Each training limited to, the		gram shall include, but owing:	not be		The QMRP will ensure that the staff are on health and hygiene.	e t sined	1/3/08
	(i) Training of oral health an		residents in the mainte /giene.	enance of	•			
	Based on rec	·FC	ot met as evidenced by review, the GHMRP fai raining was provide to	iled to			; ! :	
	The finding in	de	les:				! !	
	2007 revealed	tiji	ning records on Noven at the GHMRP failed to alth and hygiene.					
1 291	3514.2 RESII	Ė	IT RECORDS		I 291		 _	
			l be kept current, dated dividual who makes ar			See response to federal deficiency W	114.	1/3/08
	Based on rec ensure each	ord es i	ot met as evidenced by review the GHMRP fai dents records were dat ividual completing the p	led to ed and			!	
	The finding ir	alile	dest					
	See Federal)efi	ciency Report - Citation	n W114				
1 420	3521.1 HABI	.IT	ATION AND TRAINING	5	1 420		I ·	
	training to its and maintain	re s th o	nall provide habilitation idents to enable them to see life skills needed to with the demands of the	o acquire cope		See response to federal deficiency W	22 /.	1/3/8

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION NAME OF PROVIDER OR SUPF.		JER	(X1) PROVIDER/SUPPLIER/CLIDENTIFICATION NUMBER 09G171	R :	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING ADDRESS, CITY, STATE, ZIP CODE			SURVEY LETED C /29/2007
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l 420	of physical, m This Statute i Based on obs review, the Gl and training w would enable skills needed demands of th their optimum social functior the sample. (The finding in See Federal I 3521.3 HABIL Each GHMRF and assistanc the resident ' This Statute i Based on inte	and all not al	to achieve their optimum and social functioning. I met as evidenced by: tion, staff interview and repailed to ensure habilitation to acquire and maintain the more effectively with environments and to achieve one of the two residents and to achieve the standard of the second of the two residents. If ION AND TRAINING and provide habilitation, trained and the second of the two residents in accordance in its provide habilitation plan. It met as evidenced by: and record review, the	ecord ation nat life the eve d nts in N227	1 422	See response to federal deficiency W1	96	1/3/08
	assistance was accordance was for two of two (Residents #1)	s proth the side and should	,	n Plan		·		
1 429	I I		TION AND TRAINING ector shall arrange for ea	ıch	[429	See response to federal deficiency W.	<u> </u>	1/3/08
Health Regul	ation Administrati	<u></u>				· · · · · · · · · · · · · · · · · · ·		

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G171 AME OF PROVIDER OR SUPFLIER STREET ADD		(X2) MULTIF A. BUILDING B. WING	PLE CONSTRUCTION		SURVEY LETED C (29/2007		
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1 429	Individual Hat appropriately This Statute Based on staff GHMRP failer resident had I Individual Halleast annually included in the The finding in See Federal I 3521.7(f) HAI The habilitating GHMRP shall be limited to, (f) Health carruse and selfaid, care and devices, previous, the Ghabilitation at of self medic The finding in Internal		valuated and to receivation Plan, which is upon ast annually. In met as evidenced by erview and record review and record review and record review and record and recition Plan that was upone of the two resides mple. (Resident #1) Ites: Ciency Report - Citation TATION AND TRAINI and training of resident following areas: Including skills related the initiatration of medication of prosthetic and orthodore we health care, and sation, interview and record in the initiation of residents in the	y: iew, the each eived an dated at eived at dated at ents NG is by the ie, but not to nutrition, ion, first notic afety); by: ecord e the domain	1436	Sec response to federal deficie	ency W1 ≯6.	1/3/08

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION	(X:) DATE SURVEY COMPLETED
	09G171	B, WING	·	11/29/2007
NAME OF PROVIDER OR SU	- 	STREET ADDRESS, CITY	, STATE. ZIP CODE	
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1 437 Continued F	c n page 12	1 437		
1 437 3521.7(g) H	I ILITATION AND TRAININ	IG 1 437		
The habilital GHMRP sha	d vand training of residents It natude, when appropriate, he following areas:	by the	See response to federal deficiency \	W196 7 1/3/08
developmen telephone, le utilization of books, news	ic ation (including language : nd usage, signing, use of tenwriting, and availability a o minunications media, suc pupers, magazines, radio, te n I such specialized equipment ind);	and h as elevision,		
Based on ob review, the f and training	is not met as evidenced by: senation, staff interview and a illity failed to provide habilit for two of the two residents i e (Residents #1 and #2)	d record ation		
The finding	įl -			
See Federa	t eficiency Report - Citation: ; t ENT'S RIGHTS	s W196		!
Each GHMF that the righ protected in	Fresidence director shall er s of residents are observed a cordance with D.C. Law 2 ther applicable District and	nsure and -137, this	See responses to federal deficiencies W130, W137, W140, W159, W195, W209, W212, W227, W252, W257, W263.	W195,
Based on of review, the opposite of the control of	s not met as evidenced by: servation, interview and reco i IMRP failed to ensure the deach clients rights.			
The finding Health Regulation Administra	1 - 1		'	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION NAME OF PROVIDER OR SUPF		IDENTIFICATION NUMBER:		A BUILDIN B. WING_	STATE, ZIP GODÉ	. 60	(X i) DATE SURVEY COMPLETED C 11/29/2007		
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I 500	W130, W137,	eficie W 14	ige 13 ency Report - Citatior 0, W159, W195, W1 7, W252, W257, W2	96,	I 500				
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	ation Administrati	'							

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 12/12/2007 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIE (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G171 11/29/2007 NAME OF PROVIDER OR SUF 'LIER STREET ADDRESS, CITY, STATE, ZIP CODE CARECO 11 1701 24TH STREET, NE WASHINGTON, DC 20002 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (EACH DEF XENCY MUST BE PRECEDED BY FULL PREFIX (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOUL) BE REGULATOR Y ()R LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) W 000 INITIAL CON MENTS W 000 A monitoring risit was conducted from November 26, 2007 thro igh November 29, 2007. The survey was in tiated using the full survey process. A random sar iple of two clients were selected from a popula ign of four females with various degrees of disabilities. The findings r f the survey were based on observations at the home, interviews with clients and staff, and the review of records, including incident repor s. The outcome of the survey revealed that he facility failed to be in compliance with the Condition of Participation in Active Treatment. W 114 483.410(c)(4) CLIENT RECORDS W 114 Any individual who makes an entry in a client's The QMRP will ensure that the assessment is 1/3/68 record must n alte it legibly, date it, and sign it. signed by the clinician who completed it. This STANDARD is not met as evidenced by: Based on inte view and record review, the facility failed to ensure that all personnel making entries into the clients, records were signed for one of the two clients in ine sample. (Client #1) The finding includes: During the entrance conference on November 26. 2007 at 4:10 F.M. the direct care staff indicated that Client #1 has one to one support services. Review of the slient's psychology assessment dated July 1, 2007 revealed that the assessment was not signer by the person completing the assessment. W 124 483.420(a)(2) PROTECTION OF CLIENTS W 124

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above and disclosuble 90 days following the date of survey whe her or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these do cuments are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

RIGHTS

LABORATORY DIRECTOR'S OR FRCVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

DEPARTMENT OF HE ALTH AND HUMAN SERVICES CENTERS FOR MEDI JARE & MEDICAID SERVICES

	STATEMEN	T OF DEFICIENCIE:		(X1) PROVIDENCE IN THE PROVIDE				<u>OMB NO</u>	<u>. 0938</u> -0391
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	CAREGO	ROVIDER OR SUP	LIER		•	1	REET ADDRESS, CITY, STATE, ZIP CODE 1701 24TH STREET, NE	1 11/2	29/2007
I	(X4) ID	SUMMA	IV CTA	TPUCNE OF DECISION		V	WASHINGTON, DC 20002		
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_		The facility m Therefore the parent (if the of the client's and behavior treatment, and behavior treatment behavior treatment behavior the facility of Client #1 \text{\text{Modication parents}} and was a Seroquel 100 Interview with on November revealed that medications for the LPN revealed that the client medications, the LPN revealed t	st ensemble station in the column of the col	sure the rights of all clients. y must inform each client, s a minor), or legal guardian, al condition, developmental us, attendant risks of e right to refuse freatment. In not met as evidenced by: on, staff interview, and record clied to establish a system that is that were informed of their itheir medication for two of e sample. (Client #1 and Served during the morning November 26, 2007 at 6:05 stered Buspar 15 mg, d Depakote 500 mg. Sensed Practical Nurse (LPN) or at approximately 6:40 PM was prescribed these avioral management. Review is physician's orders revealed described the aforementioned day. Further interview with at the medications were client Behavior Support bruary 2, 2007 to address that included property of physical aggression, of self-injurious behaviors	W		1. The QMRP will ensure that the client's provides written informed consent, per the District's Health Care Decisions Act for in place to assist the client to manage her behaviors.	e the rapies	7/3/08
	_	nterview with	1€⊢Qu	alified Mental Retardation					

DEPARTMENT OF HE ALTH AND HUMAN SERVICES CENTERS FOR MEDI PARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIE: AND PLAN OF CORRECTION			IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(23) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUP	LIER			REET ADDRESS, CITY, STATE, ZIP CODE 1701 24TH STREET, NE WASHINGTON, DC 20002	-1	.5/2007
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W 124	approximately mother is ven client's legal considerate approximated at approximated does not have behalf regardiplacement, fir matters. Then the facility obten mother of the treatment assubsychotropic resp. Addition evidence that	2MR 9:30 involuanti asserby 1:: the a ig ha ance: wras ined reality, inciate i	ge 2 P) on November 27, 2007 at AM revealed that Client #1's ved in his life but are not the ans. Review of the client's, sement on November 27, 2007 21 PM revealed that the client ability to make decisions on his bilitation planning, residential is, treatment and medical no documented evidence that consent from Client #2's in benefits and risks of ed with the use of his ations and corresponding the facility failed to provide ituted consent had been ally recognized individual or	W 124			
	medication pa approximately Paxil 30 mg, Z mg. Review of orders reveals aforementions day. Interview 2007 at appro. Client'#2 was behavioral ma the LPN revea incorporated in 2007 to address disrobing and physical aggre self-injurious but	is on 5::25 /pre) the continuation of the cont	November 26, 2007 at PM and was administered to 10 mg, and Trazodone 50 client #2's current physician's the client was prescribed the dication and Zyprexa twice a the LPN on November 26, ely 6:40 PM revealed that ribed these medications for ment. Further interview with lat the medications were lient #2's BSP dated March 30, geted behaviors that included urbation, screaming/crying, property destruction, and liors. MRP on November 26, 2007 80 AM revealed that Client		2. Sec response to #1 above.		1/3/08

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 12/12/2007 CENTERS FOR MEDI ARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIE: OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: ()'3) DATE SURVEY A. BUILDING COMPLETED B. WING 09G171 NAME OF PROVIDER OR SUP LIER 11/29/2007 STREET ADDRESS, CITY, STATE, ZIP CODE CARECO 11 1701 24TH STREET, NE WASHINGTON, DC 20002 (X4) ID SUMMA LY STATEMENT OF DEFICIENCIES ΙD PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFLIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOUL!) BE TAG REGULATOR 'CIR LSC IDENTIFYING INFORMATION) COMPLETION CROSS-REFERENCED TO THE APPROFRIATE TAG DEFICIENCY) W 124 Continued From page 3 W 124 #2's mother and sister are involved in his life but are not the cli int's legal guardians. Review of the client #2's, ps 'chological assessment on November 27 2:007 at approximately 1:21 PM revealed that he client does not have the ability to make decis ons on his behalf regarding habilitation planning, residential placement, finances, trea ment and medical matters. There was no docun ented evidence that the facility informed Clier t#2's mother or sister of the health benefits and risks of treatment associated with the use of his psychotropic medications and corresponding BSP. Additionally, the facility failed to provide evir ence that substituted consent had been obtained from a legally recognized individual or entity. 3. The facility ailed to obtain consent prior to the use of sedatic 1 for a medical appointments 1/3/08 3.a. Sec response to #1 above. and/or to notif the clients guardian the risks and benefits of tre itments for two of the two clients in the sample. ()lient #2) a. Review of ::lient #2's physician orders on November 28, 2007 at approximately 2:00 PM revealed that in July 16, 2007, the client received Xanax 2 mg fc r ain EEG. During the enf ance conference on November 26, 2007 at 4:10 F M, the direct care staff indicated that the client las family involvement. W 130 483.420(a)(7) PROTECTION OF CLIENTS W 130 RIGHTS The QMRP will ensure that all staff are tra ned The facility must ensure the rights of all clients. on privacy issues, and that they support cli arts to Therefore, the facility must ensure privacy during exercise their rights to privacy and persons. treatment and care of personal needs. dignity.

DEPARTMENT OF HE ALTH AND HUMAN SERVICES PRINTED: 12/12/2007 CENTERS FOR MEDI >ARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIE: ()MB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (C.S) DATE SURVEY A. BUILDING COMPLETED B. WING 09G171 NAME OF PROVIDER OR SUP LIER 11/29/2007 STREET ADDRESS, CITY, STATE, ZIP CODE CARECO 11 1701 24TH STREET, NE WASHINGTON, DC 20002 (X4) ID SUMMA LY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX ID (EACH DEFI :IENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREEIX (EACH CORRECTIVE ACTION SHOULD) BE REGULATOR (CIR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROFRIATE TAG DATE DEFICIENCY) W 130 Continued Fr m page 4 W 130 This STANDARD is not met as evidenced by: Based on observation, the facility failed to ensure that clients were provided privacy or taught to exercise prive by throughout the day for one of the four clients in the sample. (Clients #2 and #4) The findings include: During observations conducted throughout the survey on Nor ember 26, 2007, Client #2 was observed not using privacy, not encouraged or taught to exer sise her right to privacy. The staff failed to provine privacy to clients and their personal issues. On November 26, 2007, the following opportunities :) leach privacy to clients was not initiated by the staff at the facility. a. At 6:30 PN Client #2 was sitting in the living room and removed her top. The direct care staff and medication were discussing her afternoon snack before receiving her medication. b. At 6:35 PM the medication nurse was observed adm nistering Client #2 her in the presence of orner clients and staff in the living room.

direct care sta f was not encouraged to close the FORM CMS-2567(02-99) Previous V rations Obsolete

intervention of served

c. At 6:45 PM Client #2 stripped her pants below the waist, while sitting in the living room, no staff

d. At 6:52 PM direct care staff was observed placing Client 12 on the toilet. The client sat on the toilet with the bathroom door wide opened. The direct are staff was observed going to the clients bedroo n to retrieve some clothes. The

Event ID: UKU111

Facility ID; 09G171

If continuation sheet Page 5 of 35

DEPARTMENT OF HE ALTH AND HUMAN SERVICES
CENTERS FOR MEDI :ARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION NG	(23) DATE	(2 3) DATE SURVEY COMPLETED		
		096171	B. WING			C		
NAME OF	PROVIDER OR SUPI L	IER		REET ADDRESS, CITY, STATE, ZIP O 1701 24TH STREET, NE WASHINGTON, DC 20002	(11/)	29/2007		
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W 130		n page 5 wrhen she was in the bathroom.	W 130			-		
W 137	e. At 7:50 PN giving Client # 1 wide opened.	eirect care staff was observed a bed bath with the bedroom door	W 137	The Residential Director (RD) w	ill train steff to			
	Therefore, the fall have the right of	t ensure the rights of all clients. acility must ensure that clients retain and use appropriate ssions and clothing.		ensure that people are able to use personal possessions, and that sta sure that they provide people will things.	their owr aff check to make	1/3/08		
	Based on obsing review, the fac li	It is not met as evidenced by; vation, staff interview and record ty failed to ensure that clients ersonal clothing for one of the four illity. (Client #3)						
	The finding inc u	des:						
	AM, Client #3 rathat had the in its environmental in at 10:30 AM, coadrawers there in on them. 483.420(b)(1)(1) The facility must that assures a full that assures a full that assures are the state of the that assures a full that a full th	7, 2007 at approximately 9:40 as observed with a pair of socks als of Client #2. During the spection on November 30, 2007 servation of Client #3's dresser ree pairs of socks with her initials CLIENT FINANCES astablish and maintain a system If and complete accounting of funds entrusted to the facility on	W 140	The Director of Disability Servic that the QMRP has copies of peostatements in their home.	cs will casure plc's banl:	1 /3/ag		
	This STANDAL C	is not met as evidenced by: serview and record review, the						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDI 24RE & MEDICAID SERVICES

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUI		IPLE CONSTRUCTION	(3) DATE SURVEY COMPLETED			
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	facility failed to full and computed funds entrust the two clients. The finding in In an attempt Clients #1 and revealed that available for rwith the Quali Professional (indicated that in the main of facility for revibank statemereview: It should indicated that Social Securit 483.430(a) QURETARDATIC Each client's a integrated, conqualified mental This STANDA Based on obserview the faccelient's active coordinated, in	rnain ste ac d to the in the ludes o review #2 or here v view re led Me MRP he ba ce an w. By t were lich be he clie Incorr ALIFI N PRO ctive t refinat al retar RD is rvatio ity fail reatme tegrate	extrain a system that assures a accounting of clients' personal ne facility on behalf of two of a sample. (Clients #1 and #2) we the financial records for a November 27, 2007 were no bank statements at the group home. Interview cental Retardation or on November 27, 2007 onk statements were located downled be brought to the system of the survey, the center of the survey, the center made available for noted that the QMRP cents received their monthly me (SSI).	W 1		,		
	The findings in	clude:						
	1. The facility	: QMF	RP failed to have client's legal			1. The QMRP will invite the person's gu family member via letter to participate in annual Individual Support Plan meeting.) tic	1/3/08

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 12/12/2007 CENTERS FOR MEDI JARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIE OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (;3) DATE SURVEY A. BUILDING COMPLETED 09G171 B. WING NAME OF PROVIDER OR SUP LIER 11/29/2007 STREET ADDRESS, CITY, STATE, ZIP CODE **CARECO 11** 1701 24TH STREET, NE WASHINGTON, DC 20002 SUMMA LY STATEMENT OF DEFICIENCIES (X4) ID PRÉFIX (EACH DEFI ; IENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION REGULATOR (OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOUL) BE CROSS-REFERENCED TO THE APPROFRIATE PREFIX COMPLETION TAG TAG DEFICIENCY) W 159 Continued Fr. m page 7 W 159 guardian or family member participated in her annual Indivic 1al Support Plan (ISP) meeting. **ISee W209** 2. The facility s QMRP failed to ensure that The QMRP will schedule a psychiatric clients who was receiving psychotropic assessment for each person who is receivir g medications rad a psychiatric assessment. [See psychotropic medications. W212] (3. The facility a QMRP failed to ensure that an 3. The RN Supervisor will schedule an objectives war developed to address self assessment to determine whether people ar: medication training program need as identified by candidates for self-medication. The QMRI will the interdiscip mary team (IDT) in the review the results of assessments when the vare comprehensiv : assessment. [See W227] 1/3/08 complete and develop programming if appropriate. The facility s QMRP failed to provide continuous ac ive treatment. [See W249] The QMRP will review each person's objectives as identified in the IPP and revis: them 5. The facility s QMRP failed to ensure that each appropriately. client's individ la Program Plan (IPP) objectives 5. The QMRP will retrain all staff to ensure that are document id consistently and accurately. program activities are accurately and considently [See W252] documented. 4. The facility: QMRP failed to revise objectives 4. The QMRP will review all IPPs and revise identified in the clients's IPP that had not been them appropriately. achieved [Se : \V257] 483 440 ACTI 'E TREATMENT SERVICES W 195 W 195 The Director of Disability Services made a change in personnel to address Active Trea ment The facility must ensure that specific active and any other concerns in the concerns in the treatment services requirements are met. home. The new QMRP started on November 28, 2007, and is assigned full time to the home Additionally, a new Residential Director, who is well experienced in active treatment and human This CONDITION is not met as evidenced by: rights, and can provide supports to people it the Based on observation, interview and record home in accordance with their ISPs and review, the fac lity failed to ensure continuous regulatory requirements, was hired and beg in active treatme it services (See W196 and W249); work on December 27, 2007. The home is ulso staffed with a new RN Supervisor who stanted in the facility faile I to ensure that clients were November 2007. The new team will provide provided privally or taught to exercise privacy

retraining to all facility staff on providing and

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MED CARE & MEDICAID SERVICES

STATEMENT OF DEFICIENC AND PLAN OF CORRECTION		CTION	ì.	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION	(3) DATE SURVEY COMPLETED	
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CAREC	<u> </u>		L			1	REET ADDRESS, CITY, STATE, ZIP CODE 1701 24TH STREET, NE WASHINGTON, DC 20002	<u> </u>	<u> </u>
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	(See W legal gu her ann (See W clients w medicat W212) objectiv medicat the intercompressive facility for Program consiste Qualifier (QMRP) revised with the The effect with the treatmer consiste specializes subpart, (i) The the client determinand (ii) The	130); lardial ual ln 209); who we tons to the face was ion tradiscipled to person the failed to the failed to the failed to the failed to the failed affect to failed are and restricted are are to full artion preventions.	he factorized at reconstruction of interest and interest at reconstruction of interest at recons	cility failed to have client's mily member participated in al Support Plan (ISP) meeting cility failed to ensure that eving psychotropic psychiatric assessment (See ailed to ensure that an eloped to address self program need as identified by team (IDT) in the essment (See W227); the are that each client's Individual objectives are documented curately (See W252); and the standation Professional sure each client's IPP was ent failed to make progress objectives (See W257). It systemic practices results in allity to adequately provide vices. WE TREATMENT Therefore a continuous active which includes aggressive, notation of a program of eric training, treatment, health services described in this sted toward: of the behaviors necessary for with as much self independence as possible; or deceleration of regression	W 1		exercising privacy and all aspects of each person's ISP. The QMRP will ensure the who are receiving psychotropic medicate received a psychiatric assessment. They ensure that the clients are properly assesseligibility for self-medication; that family members are properly notified in writing meetings and requested to attend; and the IPPs are reviewed for client progress and appropriately according to the person's por lack of progress. The QMRP and RD ensure that all staff are trained on each pIPPs and BSP, and that staff document be accordance with the protocols governing	nat people sions also y will see I for ly g of team at all d revised progress y will per on's	1/3/08
	or 1055 ,01 - 	CUITO	nt opt	not met as evidenced by:	•				

DEPARTMENT OF HE ALTH AND HUMAN SERVICES CENTERS FOR MEDI: ARE & MEDICAID SERVICES

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W 196	Based of record in clients in program made by the two #1 and #1. The find I. The find I. The find I. The find I. The following I. At 4: her bedichecking following row hungry, sitting in 3. At 5: bedroom her head present 4. At 5: The direction her pant the client in the client in the client in the sitting in the client in t	n obs eview eceive in ac y the ir clients #2) diconti dividu down down The s a cha and th again and th ct cam s up, t t com	entation the following the following the condition of the	ion, staff interviews, and acility failed to ensure that national active treatment ince with recommendations sciplinary team (IDT) for two of ided in the sample. (Clients to ensure that Client #2 is active treatment as outlined bilitation Plan (IHP). 6, 2007 Client #2's was PM to 8:40 PM revealed the client was observed sitting in	W 1		I. The QMRP will review the 24-hour treatment schedule and revise it as need QMRP will review the IPPs for the perensure that they are appropriate, and in programming for personal care and hypogramming for personal care and hypograms active treatment schedule, the BSP, and ensure that staff document programs act and timely per the established protocol QMRP will ensure that the staff are appropriately, and assist the person to exercise I privacy, and assist her to maintain her of the QMRP will ensure that staff engagedient according to her schedule, and releaving her unattended and alone in her other than at sleep time. The QMRP are ensure that the person receives appropriate places, in accordance with dietary plan. See response to W 195.	ded. The son ind clud: gions. The on o the dilPF's and courately s. The propriately her right to dignify. e the frain from from di Ri) will inter tracks	1/3/08	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDI 24RE & MEDICAID SERVICES

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MU A. BUILI	LTIPLE CONSTRUCTION	():3) DAT	C3) DATE SURVEY COMPLETED		
			09G171	B. WING			C.
CARECO	<u> </u>			5	STREET ADDRESS, CITY, ST 1701 24TH STREET, NE WASHINGTON, DC 2	TATE, ZIP CODE	1/29/2007
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8	bedroom the bedro water. IT feeding t client hel the entire finished t and sligh 6. At 5:0 wall, four 7. At 5:1 and remo undergari 8. At 5:20 room and 9. At 6:20 attempting client con nurse mix medication food and i nurse was medication consumed 10. At 6:3 exposing i 11. At 6:4 below the 12. At 6:5 client to the	alor pom he di he cli de fee che ci tiy life 8 PN stime 2 PN stime 2 PN steed 1 in steed	the client pulled her pants down per soiled adult protective (APU). the client came into the living in a chair. the medication nurse was see the client her dinner while the ed in the living room chair. The ed two spoonfuls of food. The 4 teaspoon of the client's crushed to her food. The client refused the cation. Several minutes later the served putting the remained to a jelly sandwich. The client medication sandwich. If, the client removed her top, parts bra.	S	16		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDI LARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIE AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIN	LE CONSTRUCTION	(3) DATE SURVEY COMPLETED		
		09G171	B. WING		l	C 9/2007	
NAME OF P	ROVIDER OR SUP	LIIER	17	EET ADDRESS, CITY, STATE, ZIP CODE 701 24TH STREET, NE /ASHINGTON, DC 20002			
(X4) ID PREFIX TAG	(EACH DEF)	Y STATEMENT OF DEFICIENCIES :IENCY MUST BE PRECEDED BY FULL 'CIR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLO BE	(XS) COMPLETION DATE	
W 196	13. At 7:15 P her bedroom hygiene. B. Interview v 27, 2007 reve on staff for ba On November wearing an ac dependent on morning of No observed assistaff confirme with bathing, of Review of the November 28, evidence of traffurther review failed to revea skills had been C. Review of objectives to ecommunication living skills. It did the direct oparticipate in a objectives as in 1. Given verb perform an ac with 70% accuracy of the consecutive mentions.	A, the client was escorted back to be complete evening personal little direct care staff on November alled that Client #2 was dependent the personal needs 26, 2007, the client was observed all protective under garments and staff for toileting. Also on the rember 27, 2007, the staff was thing the client with her jacket. The that the client needs assistance ressing and toileting. Ilient's habilitation record on 2007 revealed no documented in ng programs in these domains of the client's habilitation records that the client's personal care identified/assessed. The Client #2's IPP revealed thance money management, and identify activities of daily the the time during the observations and istaff encourage the client to my of the aforementioned program lentified below: I assistance, [the client] will for with an object upon request acy per sessions for three in ths.	W 196				
	Given verbidentify two ite	ः l assistance, [the client] will ाड needed to complete ADL task					

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MED CARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIE; AND PLAN OF CORRECTION		;	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(3) DATE	((3) DATE SURVEY COMPLETED	
				A, BUI	LDING				
			09G171	B. WIN	IG_		I	C 29/2007	
CAREC					17	EET ADDRESS, CITY, STATE, ZIP CODE 101 24TH STREET, NE ASHINGTON, DC 20002		2012001	
(X4) ID PREFIX TAG	: (EACH DEF	DIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
	(by touch) will consecutive r 3. Given vert toothbrush or month for thru 4. Given vert assistance, [t accuracy per trials per mon Interview with data book rev the program c was no eviden had been imp D. Interview that the client Review of Clie (BSP) dated M strategies to in 1. The client spreyent disrot 3. The client spreyent disrot 3. The client stwo layers of c stripping. In the occurs, direct with a towel pror bathroom to	i 70% ionthis al pro- al pro- e cliesession for the Qualed office; the erren ith the pro- errent #2" arch clude hould othing e eves or to redressioned.	ompts. [the client] will rinse her of the trials recorded per secutive months by 10/07. Impts and hand over hand ant] will identify coins with 75% on as measure by the record six consecutive months. MRP and review of the IPP no documentation on any of we since June 2007. There at these program objective ted since June 2007. The direct care staff indicated red to stay in her bedroom. Behavior Support Plan 30, 2007 indicated proactive is be engaged in a task as alleviate boredom. be closely supervised to wear an additional one or go to prevent or delay clothes in that clothes stripping taff should cover the client escorting her to the bedroom	W 1	96				
	throughout the	day, ∉	every day.						

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 12/12/2007 CENTERS FOR MEDI MRE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIE: (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (7:3) DATE SURVEY COMPLETED A. BUILDING C B. WING 09G171 NAME OF PROVIDER OR SUP LIER 11/29/2007 STREET ADDRESS, CITY, STATE, ZIP CODE CARECO 11 1701 24TH STREET, NE WASHINGTON, DC 20002 SUMMA LY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX ID (EACH DEFI : IENCY MUST BE PRECEDED BY FULL REGULATOR 'CIR LSC IDENTIFYING INFORMATION) (X5) COMPLETION DATE (EACH CORRECTIVE ACTION SHOUL) BE CROSS-REFERENCED TO THE APPROFINATE PREFIX TAG TAG DEFICIENCY W 196 Continued From page 13 W 196 There was no evidence that the direct care staff implemented he BSP as written. E. Review of he activity schedule for Client #2 on November 25, 2007 at approximately 10:00 AM revealed the following: 5 AM wak sup and person hygiene; 7 AM Heli in setting the take; 7:30 AM r redication; 8 AM sign breakfast; 8:30 AM c eaning the table hold dish cloth and wipe table with staff assistance. Afterward brush teeth (ri ise toothbrush). 9 AM- 4 P / Day Program; 5 PM com nunication goal (follow directions); ₁6 PM Dinr şr; 6:30 PM Fousehold chores; 7 PM Mor by Management. 7.30 PM E ath/shower (OT objective); 7:45 PM F elaxation: 8 PM Sna k, and . 8:30 Bedti ne∟ The facility fail ad to implement Client #2's activity schedule as witten. II. See response to I above. The QMRP will II. The facility ailed to ensure that Client #1 ensure that staff are fully trained to competently received active treatment in accordance with her implement and document the person's BSP ISP. 1/3/68 A. Observatio is on November 26, 2007 from 4:00 PM throu h 8:40 PM revealed the following:

FORM CMS-2567(02-99) Previous V. skins Obsolete

PM:

1. At 3:55 PM Upon entry into the facility, Client #1 was observed sleeping in her bed until 5:45

Event ID: UKU111

Facility ID: 09G171

If continuation sheet Page 14 of 35

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STATEMENT OF DEFICIENCIE AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPE	E CONSTRUCTION	(, (3) DATE \$	(3) DATE SURVEY		
	;		A BUILDING		COMPL	•		
		09G171	B, WING		445	C		
CAREC	PROVIDER OR SUF	YLIER	1(70	ET ADDRESS, CITY, STATE, ZIP CO 11 24TH STREET, NE ASHINGTON, DC 20002		29/2007		
(X4) ID PREFIX TAG) (EACH DEF.	RY STATEMENT OF DEFICIENCIES SIENCY MUST BE PRECEDED BY FULL (CR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ISHOULD BE	(X5) COMPLETION DATE		
	administered medication roadication roadication roadication roadication roadication roadication roadicated that support to preference the imprograms: 1. When asked day program in consecutive roadicated that support roadicated that roadicated that support roadicated that support roadicated that roadicated that roadicated that support roadicated that roadic	- the medication nurse he client's medication in the om; - the client had dinner; - the client threw a direct care prione on the floor; - the client was observed on d at the kitchen table for 20 - the client was observed sleeping dining room table for nearly one The client 's 1:1 support staff assisting Client #3 in her activities kills; and - the client's 1:1 support staff was rting the client to her bedroom to ming personal hygiene. th the direct care staff on 2007 at approximately 1:00 PM ne Client #1 required 1:1 staff ent behavior incidents and to lementation of the following 1, [the client] will get her things for dependently 100% for three	W 196					

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 12/12/2007 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIE (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (.(3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G171 11/29/2007 NAME OF PROVIDER OR SUP 'LIER STREET ADDRESS, CITY, STATE, ZIP CODE 1701 24TH STREET, NE **CARECO 11** WASHINGTON, DC 20002 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFI MENCY MUST BE PRECEDED BY FULL PRÉFIX (EACH CORRECTIVE ACTION SHOUL) BE CROSS-REFERENCED TO THE APPROFICIATE (X5) COMPLETION PREFIX REGULATOF (CIR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY W 196 Continued From page 15 W 196 3. Given a pattern of coins and bills, [the client] will pick out the value of money to match the price of the item shown 60% of the trials per month for three consect tive months; 4. Given vert al prompts, [the client] will prepare a simple mea with 100% independence for three consecutive n onths: When presented with arts and crafts of choice, [the client] will stay on task for up to 30 minutes independently 100% of the tails within a month for three consect ive months; and 6. [The client will participate in physical fitness exercises for 0 minutes for 12 consecutive months. Review of Client #1's IPP dated September 13, 2007, there will sino evidence that the facility implemented the aforementioned program objective since at least June 2007. Interview with the QMRP cor firmed that the program objective had no docum entation since at least June 2007. C. The 1:1 support staff failed to implement and document Client #1's Behavior Support Plan (BSP) as written. On November 26, 2007 at 6:47 PM, Client #1 was observed throving a direct care staff's cellular phone on the foor, while sitting idle after her dinner. Review of the ISP dated 2/7/07 revealed a target behavior of property destruction (throwing items).

The proactive trategies of the BSP include: engagement in a task as often as possible to alleviate bored and, provide 1:1 support staffing;

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STATEMENT OF DEFICIENCIE: (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILDI	TIPLE CONSTRUCTION	() 3) DATE	() 3) DATE SURVEY COMPLETED	
		09G171	B. WING			С
CARECO	PROVIDER OR SUP. LIE	R	1	REET ADDRESS, CITY, STATE, ZIP CODI 1701 24TH STREET, NE WASHINGTON, DC 20002	<u> </u>	<u> 29/2007</u>
(X4) ID PREFIX TAG	I CEACH DEFINEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
W 196	After the incident failed to document destruction as red 483,440(c)(2) ND Participation try the client is a minor), required unless the or inappropriate. This STANDA RED Based on record redetermined that commender participates Support Plant SP	casual verbal praise, and nate	W 196			
	The findings ir clud 1. During the intra 26, 2007 at 4: 0 P mother is very invocare. Review of C meeting was hald of review of the 1 3P's revealed seve at m interdisciplinar tea there was no cide was present at the 2. During the intra 26, 2007 at 4: 0 PM mother and sis ier a and care. Review	ance conference on November M, revealed that Client #1's lived in her habilitation and lient #1's ISP revealed the on July 19, 2007. Further signature attendance sheet lembers of the client's move that the client's mother		1. See response to W 124. 2. See response to W 124.	· . ·	1/3/08

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AND PLAN	T OF DEFICIENCIE. OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION		(3) DATE SURVEY COMPLETED	
		09G171	B. WING		444	C C	
CARECO	<u>_</u>		170	ET ADDRESS, CITY, STATE, ZIP CO 01 24TH STREET, NE ASHINGTON, DC 20002		<u> 29/2007</u>	
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W 209	revealed seve al interdisciplina y there was no wi member were pr	page 17 P's signature attendance sheet members of the client's learn were present, however, dence that the client's family lesent at the meeting. INDIVIDUAL PROGRAM PLAN	W 209				
	The comprehing	tive functional assessment must enting problems and disabilities ble, their causes.	, , , , ,	See response to W 159 #2.		1/3/08	
	Based on obs in review, the facility was receiving as psychiatric as: es	is not met as evidenced by: sation, staff interview and record y failed to ensure that clients who ychotropic medications had a sament for two of the two clients Clients #1 and #2)					
	administration on PM, revealed like and Seroquel 10 mouth. Interview November 26, 20 revealed that the behavior manage current physic and approximately 15 mg and Seromg by mouth the vice Behavior Supports 2007, to address property destricts	f the evening medication November 26, 2007, at 6:05 ant #1 received Buspar 15 mg 0 mg and Depakote 500 mg by with the nursing staff on 07, at approximately 6:20 PM, medication was prescribed for ment. Review of the client's s orders, on November 27, 2007 10:00 AM, revealed that Buspar quel 100 mg and Depakote 500 are a day was incorporated in a Plan (BSP) dated February 2, behaviors associated with on, disrobing, physical propriate touching, self-injurious					

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STATEMENT OF DEFICIENCIE AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1		PLE CONSTRUCTION	(C3) DATE	(.'3) DATE SURVEY COMPLETED			
2004			A. BUILDING B. WING			C			
		-	_ :	09G171		···			29/2007
NAME OF PROVIDER OR SUP LIER CARECO 11			17	EET ADDRESS, CITY, SYATE, ZIP C 701 24TH STREET, NE /ASHINGTON, DC 20002	ODE				
(X4) ID PREFIX TAG	(EA0	CH DEFI	HENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N \$HOUL) BE E APPROFRIATE	(XS) COMPLETION DATE
	Review Septem approxii psychot address Atypical nurse of 6:20 PM prescrib the clier Novembre 1:20 PM prescrib the clier was incompanied addressed and mass aggressi self-injuration also recovered and mass aggressi self-injuration and mass aggressi self-injura	of Climatel ber 18 ber 18 ber 18 ber 18 ber 19 ber 27 ber 27 ber 27 ber 28 ber	nt #1. 2000 10:00 nedic vices: osis. m betaled to behave the 2007 tuspes 500 red in spiral and he mission was Reviews of 10:00 ypressed in aviors or perty shavior or perty shav	's medical evaluation dated 7, on November 27, 2007 at 0 AM, revealed that the ations were prescribed to associated with a diagnosis of Interview with the medication 26, 2007, at approximately hat the medication was vior management. Review of physicians orders, on at approximately 10:00 AM, at 15 mg, Seroquel 100 mg mg by mouth twice a day and a Behavior Support Plan ary 2, 2007, to address ad with property destruction, aggression, inappropriate bus behaviors and enuresis. Trazodone 50 mg by mouth edication nurse on November 26, 2007, at 6:05 #2 received Paxil 30 mg, I Trazodone 50 mg by mouth edication nurse on November mately 6:20 PM, revealed that prescribed for behavior ew of the client's current in November 27, 2007 at 0 AM, revealed that the client at 10 mg in the evening and a BSP dated March 30, 2007, as associated with disrobing creaming/crying, physical of destruction, and ors.	W:	212			
	July 13,	2007,	on No	s medical evaluation dated ovember 27, 2007 at AM, revealed that the				;	

DEPA	RTMENT OF HI ALTH AND HUMAN SERVICE	750			!	
CENT	ERS FOR MEDI CARE & MEDICAID SERVIC	ES .			PRINT	ED: 12/12/2007 RM APPROVED
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AND PLAN	NT OF DEFICIENCIE OF CORRECTION (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE	:R: ' - / '	IULTIPLE CONSTRUC	TION		SURVEY
ļ	1	A. BU	LDING		СОМ	PLETED
	09G171	B. Wil	١Ģ			С
NAME OF	PROVIDER OR SUF ILLER				11	/29/2007
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L			1/01 24 IH STRE	ET, NE	1	
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PRÉFIX TAG	I GAUD DELI JENGY MILIST BE DOCCEDES SALEM	L PREF	PROVI	DER'S PLAN OF CORR	ECTIC N	0(5)
174	REGULATOR COR LSC IDENTIFYING INFORMATIO	N) TAG		ORRECTIVE ACTION SE FERENCED TO THE AP	HOUL) BE	(X5) COMPLÉTION DATE
W 212	<u> </u>			DEFICIENCY)	TO KELE	5416
VV 212	To amanage the fit page 19	W 2	12			+
	psychotropic nedications were prescribed to	<u> </u>	'-	•	1	
	Taddress bene (ICIS associated with a diagra-	عممت		1		
	Oction of the property Composition Com	ther				
	review of the lient's medical record reveale documented ι vidence of a psychiatric	ed no		1		1
	assessment.			,		
W 227	483.440(¢)(4) INDIVIDUAL PROGRAM PLA	N1 157.00		·		
	1 "		27			
	The individual program plan states the spec	ific	See res	sponse to W 159 #3.		
,	Objectives het assarv to meet the client's no.	~d~		-	†	1.1.0
	as identified [/ The comprehensive assessm	ent		a d	•	1/3/08
	required by paragraph (c)(3) of this section.					
			1	·		
				1		
	This STANDA RD is not met as evidenced b	v-				1 1
	- Pascu On Inte View with the observation state			į.		1
	Title view and eclord review the facility falled	to		1		1
	Glisure filet a : Colectives was developed to					1
	address self n edication training program need identified by the interdinal line.	ed as				1
	identified by the interdisciplinary team (IDT) is comprehensive assessment for one of the two	n the		Ť		
	clients in the sample. (Client #1)	/o		;		1
	ji '}			1		
1	The finding includes:			1		
	On New They are			i 1		
	On November 26, 2007 at 6:05 PM, Client #1	was		1		1
, ,	ABORDADO INCIDENTE LA PROPERTA DE LA CARRESTA PARA			. :		
] (The Licensed Practical Nurse (LPN) prepared client's medicalions, poured a cup of water are specified the state.	the		1		
, ,	SPOOT (EULI) IN SPONS THE SPONSOR IN SPONSOR			!		
1.5	Singluic muise Douten the Water into the air-a-	's				
, .	module 現れば DL ISB The hurse also took tha			; !		1
, ,	Subjute blood & logic interview with the con-					
1 **	ruicaled tild. Te client does not participate to	a				j
1	self medication program. Review of the self medication as: assement dated August 8, 2007					1
11	raicated fildt i 16 cilent world benefit from a	1		1]
ת	modified versic n of a self medication program			!	1	1
.	The state of program	•	'	-		ľ

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G171			TIPLE CONSTRUCTION	(2 3) DATE	() 3) DATE SURVEY COMPLETED	
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		B. WING		1 11/	C 29/2007	
NAME OF PROVIDER OR SUP LIER CARECO 11		ł	REET ADDRESS, CITY, STATE, ZIP C 1701 24TH STREET, NE WASHINGTON, DC 20002		<u> </u>	
(X4) ID PREFIX TAG	(EACH DEF)	Y STATEMENT OF DEFICIENCIES I JENCY MUST BE PRECEDED BY FULL F (CIR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULIJBE E APPROFRIATE	(X5) COMPLETION DATE
W 249	Review of the dated Septerr goal or object in self medication Ac which include perform during. The IPP failed this area 483.440(d)(1) As soon as the formulated a deach client must treatment proginterventions and frequency objectives idea plan. This STANDA Based on observerification, the continuous acticitients in the same the findings in the same frequency objectives idea plan.	e Individual Program Plan (IPP) roer 7, 2007 revealed no program the for the client to receive training ion. A data sheet was in the ministration Record (MARs) book steps in which the client should the medication administration. to identified program objective in PROGRAM IMPLEMENTATION interdisciplinary team has lient's individual program plan, stireceive a continuous active ram consisting of needed incliservices in sufficient number to support the achievement of the tified in the individual program RED is not met as evidenced by: reation, staff interview and record facility failed to provide the treatment for one of the two turple. (Client #2) clude: iervations conducted on November 1:00 PM until approximately 8:40	W 249			1/3/68
	#2:	e following observations for Client the client was observed sitting in				
	bediooin, t	, юде. 			1 1	

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STATEMENT OF DEFICIENCIE: (X1) PROVIDER/SUPPL AND PLAN OF CORRECTION IDENTIFICATION N		(X1) PROVIDER/SUPPLIER/CLIA	IER/CLIA (X2) MULTIPLE CONSTRUCTION			(2.3) DATE SURVEY		
	OF CORRECTION	IDENTIFICATION NUMBER:	ı	ILDING			COMPLETED	
		09G171	B. WI	NG		14/	C 29/2007	
CARECO			,	170	ET ADDRESS, CITY, STATE, ZIP CODE 01 24TH STREET, NE ASHINGTON, DC 20002		29/2007	
(X4) ID PREFIX TAG	(EACH DEFI : ENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
	b. At 4:55 PN, the screaming from her sitting in her chair, a according to shaff. c. At 5:00 PN the conthe wall. d. At 5:02 PV the conthe wall. d. At 5:02 PV the conthe direct care staff her pants up, hree the client complied. e. At 5:04 PN the conthe client complied. e. At 5:04 PN the control of the staff was observed in the staff sheet in the staff's legithe entire potato chips we are find the staff's legithe entire potato chips we are find the staff's legithe entire potato chips we are find the staff's legithe entire potato chips we are find the staff's legithe entire potato chips we are find the staff's legithe entire potato chips we are find the staff's legithe entire potato chips we are find the staff's legithe entire potato chips we are find the staff's legithe entire potato chips we are find the staff's legithe entire control of the staff's legithered entire control of the staff's leg	client was overhead bedroom. The client was alone listening to music, client was banging her head client pulled her pants down, frequested that the client pull times. After multiple request clirect care staff retrieved a and water. The direct care feeding the client potato chips nt held onto the direct care time of feeding. After the hished the client grabbed both only lifting him from the floor. Items banged her head on the client pulled her pants down ult protective undergarments client came into the living air. Intermoved her top, exposing tent pulled her pants down	W	249				
'		ient was observed sitting on		1		ĺ		

DEPARTMENT OF HE ALTH AND HUMAN SERVICES CENTERS FOR MEDI ZARE & MEDICAID SERVICES

AND PLAN OF CORRECTION			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ı	NULTIPLE ILDING	CONSTRUCTION	() 3) DATE COMP	SURVEY LETED
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W 249	1. At 7:1 bedroom 2. Intenthat the Review (BSP) distrategis a. The coften as	t with 5 PM n to co view v client of the ated n sto in possi	hould be engaged in a task as plento alleviate boredom. hould be closely supervised to	W2	249			
W 252	two layers stripping occurs, or bathroughout throughout There was impleme 483,440(Data rela specified objective terms.	is of c In the lirect well proportion to should the should the should the lirection of the	hould wear an additional one or othing to prevent or delay clothes e event that clothes stripping are staff should cover the client or to escorting her to the bedroom redress. provide frequent verbal praise day, every day. vidence that the direct staff lient #2's BSP as written. PFOGRAM DOCUMENTATION accomplishment of the criteria nt individual program plan the documented in measurable	W 28	52	See response to W 196 #1.		1/3/08

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDI :ARE & MEDICAID SERVICES

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AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPL IDENTIFICATION N	IER/CLIA (X2) MUI UMBER: A. BUILD	LTIPLE CONSTRUCTION DING	(0.3)\DATE	O. 0938-039 SURVEY PLETED
NAME OF		09G17	1 B. WING			С
CAREC				TREET ADDRESS, CITY, STATE, 2 1701 24TH STREET, NE WASHINGTON, DC 20002	ZIP CODE	/29/2007
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	Based on obserview, the facilient's Individual objectives we clients in the state of the findings in the findings in Evening obseed 26, 2007 from PM revealed the state of the finding room on the bedroom on the cking on the sitting in a character of the direct care pants up, the client completed of the bedroom along the bedroom along the bedroom where the state of the client completed in the client completed the state of the bedroom where bedroom where the state of the client completed in the client client completed in the client	invation, staff interview, a lility failed to ensure that a lility failed. The client was observed a line client who remained a line client was affected that the client relient pulled her pants are was no intervention. The client pulled her pants staff requested that the client remained in the line cli	each ehavioral two /ember ely 8:40 for Client sitting in After to the // as ent was client's nging not down, ient pull equest entered	DEFICIEN	ICY)	
fe c	eding the clier	cilicare staff was observed it potato chips and water. the direct care staff's leg d				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDI JARE & MEDICAID SERVICES

	FOF DEFICIENCIES OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION	(3) DATE SURVEY COMPLETED		
	:	:	09G171	B. WING		1	C 1/29/2007	
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W 252	the entire feer finished the cand slightly lift. At 5:08 PM wall, four times g. At 5:12 PN and removed undergarmen. h. At 5:20 PN room and sat i. At 6:20 PM attempting to client was sea client consum nurse mixed 1 medications in food and med nurse was observed in the same of the sa	ing. ent g ng h the c the s the red th ed in ed the callo ente the c the	After the potato chips were rabbed both of the staff's legs im from the floor. client banged her head on the client pulled her pants down polled adult protective PU). client came into the living hair. medication nurse was a client her dinner while the part of the client refused the part of the client refused the part of the client refused the putting the remained client sandwich. The client ication sandwich. client removed her top, is bractive to the client pulled her pants down	W 252				
					!			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 12/12/2007

CENTERS FOR MEDI MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIE O<u>M</u>B <u>NO. 093</u>8-0391 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (2:3) DATE SURVEY A. BUILDING COMPLETED 09G171 B, WING NAME OF PROVIDER OR SUP 'LIER 11/29/2007 STREET ADDRESS, CITY, STATE, ZIP CODE CARECO 11 1701 24TH STREET, NE WASHINGTON, DC 20002 (X4) ID SUMMA IT STATEMENT OF DEFICIENCIES PRÉFIX (EACH DEF. HENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION; PREFIX (X5) COMPLETION REGULATOF / ()R LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOUL) BE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE **DEFICIENCY**) W 252 Continued Fr. m page 25 W 252 Review of Clin II #2's Behavior Support Plan (BSP) dated I larch 20, 2007, on November 27, 2007 at approximately 10:00 AM revealed that staff were to record maladaptive behaviors on the Antecedent B :havior Consequence (ABC) charts. On Novembe 27, 2007 at 3:00 PM, review of the data chart revialed that the client #1 had no maladaptive t ≥haviors. Review of the behavior data failed to eflect the behavior observed on November 26 2007. There was no evidence that the data had I erin collected in accordance with the BSP for the client, which was necessary for a functional assessment of the client's progress. 483.440(f)(1)(i) PROGRAM MONITORING & W 257 W 257 CHANGE The individual program plan must be reviewed at See response to W 195 and W 196 least by the qual fied mental retardation professional and revised as necessary, including, but not limited to situations in which the client is failing to prograss toward identified objectives after reasonal le efforts have been made. This STANDA (C) is not met as evidenced by: Based on interview and record review, the Qualified Men al Retardation Professional (QMRP) failed to ensure each clients Individual Program Plan IPP) was revised after the client failed to make progress with the identified objectives, for one of the two clients included in the sample. (Client #1) The findings in clude: The QMRP fai ∋c to revise Client #1's programs as performanc a measures reflected a lack of progress. The client's documentation and IPP were reviewed on November 28, 2007 at 12:30

FORM CMS-2567(02-99) Previous Vi sions Obsolete

Event ID: UKU111

Facility ID; 09G171

If continualion sheet Page 26 of 35

DEPARTMENT OF HE ALTH AND HUMAN SERVICES CENTERS FOR MEDI ;ARE & MEDICAID SERVICES

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W 257	PM. 1. According on November following obje a. The client "Given a writted dial the number of the program documentation reflected that the 2007 Individual the objective was The objective revisions.	o Clie 28, 20 thres ad ar n lele r corr e dur hree data since colie dual s eviriti vas re	ent #1's IPP that was reviewed 007, 12:30 PM reflected the : n objective which stated ephone number, [the client] will rectly with verbal prompts ing the trials conducted during consecutive months". Review documentation revealed no e March 2007. The IPP ent continued this objective in Support Plan (ISP). The ten from the previous ISP, eimplemented without	W 2	257			
	"Given a patte pick out the value the items show consecutive or data documen since June 22 client continue. The objective ISP. The objective revisions. c. The client of "Given verbal simple meal who consecutive of meal who consecutive of meal documents ince June 200 continued this	n of cue of n 60% onthe ation 2007 I this rative v ad an remph 100 onthe ation 7. This ect	coins and bills, [the client] will money to math the price of of trials per month for three. Review of the program revealed no documentation. The IPP reflected that the objective in the 2007 ISP ewritten from the previous was reimplemented without objective which stated that the client] will prepare a low independence for three. Review of the program revealed no documentation are IPP reflected that the client ive in the 2007 ISP. The en from the previous ISP.					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDI JARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIE AND PLAN OF CORRECTION		,	(20)			OMB NO. 0938-039			
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31434-	<u> </u>		09G171	B. Wil	NG_		1 .	Ç	
NAME OF	PROVIDER OR SUP	LIER	-		ST	REET ADDRESS, CITY, STATE, ZIP CODE		1/29/2007	
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	<u> </u>				_	DEFICIENCY	i		
W 257	991111111111111111111111111111111111111	m pa	ge 27	W 2	257				
	The objective	Was r	eimplemented without		•				
	revisions							1	
	d. The client	කේ ක	n objective which stated						
	vvnen preser	ted w	ith arts and crafts of choice				!		
	Ime client) wit	Stay (on task for up to 30 minutes				1		
	independentily	100%	of the trials within a month				1		
	program data	docum	e months". Review of the pentation revealed no				1		
_	documentatio	I Since	June 2007 The IPP				:		
	reflected that	nei olie	ent continued this objective in [:	,	į		
	me 2007 ISP	The o	Diective was rewritten from					ļ	
	reimplemente	vP⊰ H Lvzitha	he objective was		1				
	e. The client	ad an	objective which stated "[The				!		
	Cilenti will part	cipate	! IN Dhysical fitness everciees /		1	1	;		
	Review of the	TOT 12 Venden	consecutive months".				1		
	revealed no do	Cume	ntation since June 2007.				į	1	
	I ne IPP reflect	ed tha	at the client continued this		- 1		1 .	[]	
	objective in the	2007	ISP. The objective was	1			1		
	Was reimplem	he pre	evious ISP. The objective without revisions.				į		
		1				J I	•	. [
	Interview with	he _i QN	IRP confirmed that there				1	1	
	was evidence	of Jacu	umentation for the				} 		
W 262	aforementione	prog	rams.				; !		
	CHANGE	- KO	GRAM MONITORING &	W 26	32		•		
						The Human Rights Committee is sel			
	The committee	luora	d review, approve, and			theet on January ### and will review	erthe been	.] [
1	monitor malyig.	≀a⊨pro	Orams designed to manage			restrictive measures for both people	in the		
	in the opinion	i lavio fithe c	or and other programs that, committee, involve risks to			sample.		1/3/20	
	client protectio	and r	ights.				1 !	11-1108	
	•	1					•		
	This STANDAL!	D.is r	not met as evidenced by:						
							-		
RM CMS-256	17(02-99) Previous Vi	sions Ob	solete Event (D-1)(VI)444	· · ·					

DEPARTMENT OF HE ALTH AND HUMAN SERVICES CENTERS FOR MEDI LARE & MEDICAID SERVICES

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W 263	Based on obserview, the fa (HRC) failed to restrictive mentine sample. (The finding in On November PM, review of the Qualified I (QMRP) reverthe HRC had techniques (i.c. psychotropic refor Clients #1 483.440(f)(3)(CHANGE) The committee are conducted consent of the minor) or legation of the minor or legation. The finding incommittee the use of behavior the use of behavior the client, pareguardian for the (Clients #1 and The finding incommittee facility failed).	ervation in the control of the contr	con, staff interview and record Human Rights Committee ew and approve the use of a for two of the two clients in a #1 and #2) control at approximately 1:00 RC minutes and interview with Retardation Professional e there was no evidence that wed the use of restrictive avior support plan and ations) to manage behaviors [See W124] DGRAM MONITORING & and insure that these programs with the written informed, parents (if the client is a lian. not met as evidenced by: n, staff interview and record led to ensure that each revention technique, including modification drugs was written informed consent of the client is a minor) or legal are two clients in the sample.	W 2		See response to W 124.			1/3/68

DEPARTMENT OF HE ALTH AND HUMAN SERVICES CENTERS FOR MEDI ARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIE AND PLAN OF CORRECTION			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		PLE CONSTRUCTION	703	DATE :	SURVEY ETED
		09G171 B. WING				11/	C 29/2007		
NAME OF F	ROVIDER OR SUP	LitäR		'	17	EET ADDRESS, CITY, STATE, ZIP CODE 701 24TH STREET, NE /ASHINGTON, DC 20002			
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W 263 W 331	Clients #1 and sedation. [Se	#2's : \V1:	Behavior Support Plan and	W 2					
	The facility m	st pro	ovide clients with nursing nee with their needs.	W 3	131				
	Based on obs review, the fac services in ac	invationalisty facility facility	s not met as evidenced by: on, interview and record alled to provide nursing nce with the needs of two of ded in the sample (Clients			-	1		
	The findings in	clude							
	a. Review of 1 November 28, revealed that t consultation or recommendati a normal vagir two years if the	lient 2007 ie clie Apri on fro al exc pap	se failed to schedule medical iments for Client #1, timely. #2's medical record on at approximately 12:30 PM ent had a gynecology I 26, 2007. The om the consultation indicated amination and to follow-up in smear is normal. Howevers of the pap smear in the			1. See response to W 195. The new RI Supervisor will hold scheduled grand least monthly with the Primary Care P and the QMRP to ensure people's med are addressed completely and timely.	70บ) เ ให้งข้อ	cian	1/3/08
	November 28, revealed that t January 12, 20 unsuccessful. Nurse on Nove indicated the s Care Physician	2007 e clie 77. T nten riber 18 Wc	t #2's medical record on at approximately 12:30 PM ent had a mammogram on the examination was view with the Registered 29, 2007 at 2:20 PM, buld speak with the Primary eek later to request a breast me of the survey, there was				1		

DEPARTMENT OF HE ALTH AND HUMAN SERVICES CENTERS FOR MEDI 24RE & MEDICAID SERVICES

	T OF DEFICIENCIES OF CORRECTION	!	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	LTIPLE CONSTRUCTION	(0:3)	DATE S	
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NAME OF F	PROVIDER OR SUP					L_	11/2	<u> 29/2007</u>
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W 331	Continued Fr	m pa	ge 30	W 33	1		 	
	no mammogr	ımı or	an appointment scheduled.		<u> </u>	:		
	2. The facility treatment ser health. [See	failed ices f V356]	d to ensure comprehensive for the maintenance of dental]	,	2. See response to #1 above. The RD w schedule another dental appointment and that staff take the required records. Dent recommendations will be completed one informed consent is acquired.	d d ns all	ł	13/68
W 336	authorized pe storage area.	scins [Siee	d to ensure that only have access to the drug W383] JRSING SERVICES	W 336	3. The Director of Disability Services wi provide training to the QMRP, RD and stauthorized access to the drug storage are lock combination to the drug storage are changed.	tailo a.T.	he	1/3/68 1/3/08
	certified as no review of their	: need healti	ust include, for those clients ding a medical care plan, a h status which must be on a equent basis depending on					
	Based on inte failed to ensure by the nursing	view a that staff of for or	s not met as evidenced by: and record review, the facility a health status was reviewed on a quarterly or more ne of the two clients in the			1		
	The finding inc	.ludes	c	I				
	November 27, revealed that a completed on the medical re assessment h.	n ann lugus ord n d not	s medical record on at approximately 12:00 PM hual nursing assessment was st 8, 2007. Further review of evealed that the first quarter to been completed. Interview Nurse confirmed that the		The new RN Supervisor will complete the quarterly assessment.	 e		1/3/08
W 356	quarterly asse	SINET C/MF	nt had not been completed. PREHENSIVE DENTAL	W 356	See response to W 331 #1 and #2.			1/3/08
	The facility mu	it ens	sure comprehensive dental			1 -		

DEPARTMENT OF HE ALTH AND HUMAN SERVICES CENTERS FOR MEDI JARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIE AND PLAN OF CORRECTION			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(2:3)	3) DATE SURVEY COMPLETED		
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W 356	treatment ser needed for re restoration of health. This STAND/ Based on inte failed to ensu services for the	rices left of leeth RD: i View e cor e ma	ge 31 that include dental care pain and infections, and maintenance of dental s not met as evidenced by: and record review, the facility aprehensive treatment intenance of dental health for its in the sample. (Client #2)	W 3	356			-		
	with many misconsultation of that the client teeth removed appointment a dental surgeo the medical becould not asset the time of the scheduled. The received the medical the received the modern becomber 6, 3483.460(I)(2) RECORDKEE Only authorize keys to the driver the standard on obstacility failed to	28, 2 sing I sted I he did the check the common one. I he common one of the common o	eeth. Review of the dental December 6, 2006 revealed to have additional seven ectient had a dental alled on March 20, 2007 with a edirect care staff did not take derefore, the dental surgeon ectient laboratory values. At eay, there was no appointment was no evidence that the client mended dental care since in STORAGE AND sons may have access to the rage area. Inot met as evidenced by: In and staff interview, the re that only authorized is to the drug storage area.	W 3	83	See response to W 331 #3.			1/3/08	

DEPARTMENT OF HEALTH AND HUMAN SERVICES <u>CENTERS FOR MEDI ZARE & MEDICAID SERVICES</u>

STATEMENT OF DEFICIENCIE AND PLAN OF CORRECTION		:	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(2:3)	DATE S	
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W 440	PM, a reques Record (MAR He indicated inurse's statio was observed and retrieve ti Qualified Mer (QMRP) on N direct care stanumbers from personnel red approximately the direct care medication en 483.470(i)(1) I The facility may quarterly for e This STANDA Based on staff facility failed to all shifts. The finding ind Interview with Professional (inpattern on Non-	itide: 25, 2 of the 25, 2 of the 3 was the At In	2007 at approximately 4:15 e Medication Administration is made to the direct care staff. e MARs were locked in the 4:30 PM, the direct care staff lock the nurse's station door in it. Interview with the etardation Professional ber 29, 2007 revealed that the eived the combination 2MRP. Review of the 2010 November 28, 2007 at PM revealed no evidence that or the QMRP were trained dee. EUATION DRILLS Id evacuation drills at least hift of personnel. Is not met as evidenced by: view and record review, the evacuation drills quarterly on S: ualified Mental Retardation P) and review of the staffing er 29, 2007 at approximately the scheduled shifts are as	W 4		The new RD and the QMRP will ensure drills are completed and documented in accordance with the schedule and regula			1/3/68

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STATEMENT OF DEFICIENCIE AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			DATE S COMPLE	ETED -
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W 440	3rd Shift 11.F Weekends 1st 7 AM to 7 2nd 7 PM to Further intervitely was requested to the evacuation of the evacuation	PIM AM Pew with the QMRP revealed that the fired to conduct a drill once per that the facility failed to hold fire that the facility failed to hold fire ills since their move into the facility There was no evidence that fire ducted quarterly on all shifts. NIFECTION CONTROL The facility of the control, and investigation of infection in able diseases. ARID is not met as evidenced by: The failed to implement infection in the control, and investigation of infection in the control in	W 4		ing o	n	1/3/08
W 483	observed pulliner soiled adultation (APU's), while APU on the floobserved pick gloves on. 483.480(d)(2) The facility mu	ing her pants down and tearing off at protective undergarments in her bedroom. The client put the or. The direct care staff was and up the soiledAPU's, with no DINING AREAS AND SERVICE at st provide table service for all and will eat at a table, including	W 4	83			

DEPARTMENT OF HE ALTH AND HUMAN SERVICES

CENTERS FOR MEDI: ARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION

			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(> 3)	DATE SU COMPLE	
			09G171	B. WIN				1	C 9/2 <u>007</u>
NAME OF P	ROVIDER OR SUP	LIER			13	EET ADDRESS, CITY, STATE, ZIP CODE 701 24TH STREET, NE VASHINGTON, DC 20002			
(X4) ID PREFIX TAG	(EACH DEFI	HENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULIDI	ŘΕ	(X5) COMPLETION DATE
W 483	Continued Fro	m pa	ge 34	W 4	83				
	Based on obs facility failed t	ervati • prov	is not met as evidenced by: ion and staff interview, the vide enough table room for five ng in the facility.			The QMRP will ensure that people who will eat the table have adequate comfor space to do so.	tab c	and	18/08
	The finding in	:lude	s:						
	alone. The the bedroom with The direct car client potato conto the direct feeding. After	e clire a bag e stat ips a care the p	ent remained in the bedroom ect care staff entered the g of potato chips and water. If was observed feeding the and water. The client held staff's leg during the entire potato chips were finished the of the staff's legs and slightly floor.						
	to fed the clien seated in the consumed two mixed 1/4 teamedications in food and medimedication nuremained medication nuremained medication.	t her ving spoor poor to he catio	edication nurse was attempting of dinner while the client was room chair. The client confuls of food. The nurse of the client's crushed food. The client refused the number observed minutes later, the was observed putting the consinto a jelly sandwich. The permedication sandwich.						
		,							

FORM APPROVED

STATEMENT AND PLAN C	OF DEFICIENCIE OF CORRECTION	,	(X1) PROVIDER/SUPPLIES IDENTIFICATION NUM 09G171	R/CLIA MBER:	(X2) MULTIP A. BUILDING B. WING	LÉ CONSTRUCTION	O 3) DATE SU COMPLE 0 11/2	TED
NAME OF D	ROVIDER OR SUP	1 IIER	030111	STREET ADD	RESS, CITY, S	FATE, ZIP CODE		_
CARECO	<u> </u>	Litary		1701 24TH WASHINGT	STREET, N	002		
(X4) ID PREFIX TAG	(EACH DEE	CIFNO	TEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PRÉFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OUL) BE	(X5) COMPLETE DATE
R 000	INITIAL COM A licensure s November 26 The survey w process. A reselected from various degree The findings observations and staff, ian- incident reporevealed that with the Con Treatment. 4701.5 BAC The criminal criminal histo contract wor in all jurisdic employee or resided with check. This Statute Based on the failed to ensidisclosed the employee or seven (7) ye the prospect	VIEN Ney 200 as ini ndor a por a por a the at the ition GRO is not in the is not a revial recont a respective cont a respective a respective cont a respec	TS was conducted from f through November tiated using the full s n sample of two residuation of four fema	29, 2007 Jurvey Jents were Jurvey Jurvey JUREMENT JUREMEN	R 000	The Director of Human Resources withat all direct care staff have criminal checks completed and in their files.	ill er sure	1/3/68
	The finding Review of the 2007 reveal	i iclud	des: - - sonnel files on Nove 	mber 29, rovide				
	julation Administra	on"			·····	TITLE		(X8) DATÉ
LABORATO	RY DIRECTOR'S C	I PRO	VIDER/SUPPLIER REPRES	ENTATIVE'S SIG	NATURE		IF an all	nuation sheet 1 of 2

PRINTED: 12/12/2007 FORM APPROVED

STATEMENT AND PLAN O	OF DEFICIENCIE F CORRECTION	3	(X1) PROVIDER/SUPPLIEF IDENTIFICATION NUM 09G171	ABER:	A. BUILDING B. WING			DATE SUR COMPLETE C 11/29/	ED .
NAME OF PI	ROVIDER OR SUF	PLER		1701 24T	DRESS, CITY, S H STREET, N STON, DC 20	TATE, ZIP CODE			
		- i	ATEMENT OF DEFICIENCIES		IDN, DC Z	PROVIDER'S PLAN	OF CORRECTION		(X5) COMPLETE
(X4) ID PREFIX TAG	CEACH DES	CLENC	Y MUST BE PRECEDED BY LSC IDENTIFYING INFORMA	FULL	PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD! FO THE APPRC≓R	3E	DATE
R 125	Continued F	orn p	age 1		R 125				
	evidence of direct care s	rimin aff (S	al background checks taff #4, #9, #13 and #	s for four 14).					
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	ulation Administ			<u>.</u>					

CARECO

D: Gail Duggers Sheila Pannell Patricia Vanbenen

Ep: Marsha Kompson, Care W

Ro: POC for 1701 a 6th St. NE

DT: Jan. 3, 2008

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		FLOW SH	m H	
Restorative Feeding Program	WEIGHT	% Break 2 3 4 5 8	7 8 9 10 11 12 13 14	15 18 17 18 19 20 21 22 15 18 17 18 19 20 21 22
R - Refused or Special Needs		INI		
CITIET % (percentage)		INT PLAN A		
DIET		% Dinner		
☐ Ambulate Special Needs				
	-	INT		
[] Corrective devices	-			
22				
3. Nulfterne Only	•			
4. SAM- 4PM		INT		
☐ Range of Motion/Location				
☐ AAROM ☐ AROM				
	,	INT		
SIGNATURE / TITLE	NATION AND ADDRESS OF THE PROPERTY OF THE PROP	RESIDENT LO	to	ROOM
F. James	12	PROGRAM START DATE SPECIAL NEEDS OR INS	TRUC	
		amall bot	to laips,	18
DATE 8/1/07	TOP TOWN	OXXD		
	2007			